Brookside Counseling
Intake Form

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian(If under 18 years):

_____
(Last) (First) (Middle Initial)

Birthdate: / / / Age: Gender ☐ Male ☐ Female

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

What is the best phone number to contact you? _____

In case of an emergency who would you like notified?

Name: Number: ( )

Referred by: _____

Are you currently employed? ☐ Full-time ☐ Part-time ☐ Disabled
☐ Medical Leave ☐ Laid off ☐ Retired

Current Employer: _____

Job Description: Date Employed: _____

Reason for counseling or statement of problem: _____

_____

_____

Please check any of the following symptoms that you are experiencing:

☐Heart beating fast ☐Low self-esteem ☐Easily tired ☐Low energy
☐Problems Sleeping ☐ Restless ☐Irritable ☐Trembling/shaky
☐Feelings of hopelessness ☐Depressed Mood ☐Feeling isolated
☐Feelings of helplessness ☐Difficulty concentrating
☐Shortness of Breath ☐Easily startled

Are you being treated for any of these symptoms? ☐ Yes ☐ No

Have you experienced any suicidal thoughts? ☐ Current ☐ Past ☐ No

If current, please describe:

Have you ever attempted suicide? ☐ Yes ☐ No If yes, please explain:

Have you experienced any homicidal thoughts? ☐Current ☐Past ☐No

If current or past, please explain:

Have you ever assaulted anyone? ☐ Yes ☐ No If yes, how many times and explain?

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Dating

Assessment of current relationship: ☐Good ☐Fair ☐Poor

Do you have any children? If so, give names and ages:

Mothers Name Age

Fathers Name Age

Information you would like to include about your parents.

Do you have any brothers or sisters? If so give names and ages:

Do you have any conflicts with family members? ☐ Yes ☐ No

Do you consider yourself to be a religious person?

Did you attend church growing up?

Do you currently practice any religious beliefs?

Physical Health: When was your last physical exam?

Doctors name:

Do you have any diagnosed illness or conditions?

Are you taking any medications? If yes, please list medications:

Are you taking any psychiatric medications? If yes, please list:

Please list any specific sleep problems you are currently experiencing:

How many times a week do you generally exercise?

What type of exercise do you participate in?

Please list any difficulties you experience with your appetite or eating patterns.

Alcohol/Drug use: Date of last drug or alcohol use:

Amount used on that date:

How much consumed per week? Per Month?

Has anyone in your family ever been diagnosed with a mental illness?

If yes, what is their relationship to you and their type of illness?

Have you experienced any of the following:

☐Physical Abuse ☐Emotional Abuse ☐Sexual Abuse ☐Verbal Abuse

What significant life changes or stressful events have you recently experienced?

What would you like to accomplish during treatment?

Client Signature Date

Date

Therapist Signature/Credentials